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TO THE EDITOR, *Genitourinary Medicine*

Treating chancroid: summary of studies in South Africa

Sir,

We were interested to read the article by Ballard *et al*[1] which summarised the effective treatments for chancroid with particular reference to single dose therapies. Guidelines on the general management of genital ulcer disease in Southern Africa were also given. However, patients who are HIV Ab positive are not immune to genital ulcer disease and this article failed to consider the effects of concommitant HIV infection on both natural history and treatment efficacy.

Cameron *et al*[2] concluded that treatment failure in chancroid using single doses of trimethoprim-sulphonamide or a quinolone was significantly associated with HIV Ab positivity. Treatment failure appeared to be a good clinical indicator of such positivity. Furthermore, the article suggested the use of benzathine penicillin together with single dose anti-chancroid therapy in genital ulcer disease where diagnostic facilities are limited.

It has been shown that benzathine penicillin fails to reach treponemacidal levels in CSF.[3] Reports on the development of neurosyphilis after treatment with benzathine penicillin[4] strongly suggest it is not optimal therapy even in the immunocompetent. Neurological relapse after treatment of early syphilis with benzathine penicillin in HIV Ab + patients has now been reported.[5,6] Moreover, the natural history of syphilis in HIV infection is not yet fully understood but reports suggest that there may be an accelerated progression of late complications in such patients who receive treatment.[6]

Thus, the management of genital ulcer disease along the lines suggested without taking into account HIV status would appear to leave a susceptible population open to the possibility of ineffective chancroid treatment and the late complications of syphilis.

Yours faithfully,
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TO THE EDITOR, *Genitourinary Medicine*

Evaluation of abnormal cervical cytology results in a genitourinary clinic

Sir,

Drs Coker *et al* in their letter to this journal[1] expose the tendency for female genitourinary patients to possess abnormal cytology necessitating colposcopy. In our colposcopy clinic we have attempted to answer the corollary: do colposcopy patients have STDs we are failing to diagnose?

Modern theory holds that CIN is a sexually transmissible disease.[2] Long established thought in genitourinary medicine makes it necessary, in the presence of an STD, to search for others. It may be expected therefore that STD will be found in colposcopy clinic patients.

The cost effectiveness of identifying and treating all such STDs at one consultation appears attractive. In the Jessop Hospital, the facilities are ideal to perform this function since the clinic is co-managed by two consultants; one gynaecologist (VAB) and one genitourinary physician (DAH). Genitourinary patients with abnormal cytology are managed "in-house" and if necessary are then referred for appropriate treatment to Jessop Hospital.

Table *Positive findings in 75 consecutive colposcopy patients*

Chlamydia trachomatis	1
Ureaplasma urealyticum	2
Candida albicans	7
Gardenerella vaginalis	6
Ureaplasma + Gardenerella	2
Ureaplasma + Candida	5
Anaerobes + Gardenerella	1
Mycoplasma, Gardenerella + Candida	1
Mycoplasma, Gardenerella + Ureaplasma	1
Group B Streps. + Candida	1
Total	27

Seventy five consecutive patients referred directly to the Jessop Hospital for colposcopy were screened. These were females with abnormal cytology from sources other than genitourinary medicine.

A sexual and medical history noting age, marital status, age at first intercourse and number of sexual partners was solicited. Patients with a recent (one month) history of antibiotic ingestion were excluded.

Tests comprised urethral swab for Gram staining and culture, high vaginal specimens for dark ground illumination, Gram staining and culture, and cervical samples for Gram staining and viral culture. Endo-cervical testing for *Chlamydia trachomatis* was performed with a monoclonal antibody labelled with fluorescein (Microtrak, Syva). Samples were obtained after cytology had been performed, but before formal colposcopic procedures.

Positive findings are shown in the table. If organisms of low potential risk or commensal status are excluded, then carriage of pathogens in this group of patients is seen to be low. Only one patient had *C trachomatis* with 11 other patients having ureaplasma and/or mycoplasma. Eleven patients had mixed infections, and 13 others were only candida (7) or gardenerella (6).

Review of sexual, contraceptive, smoking and obstetric history failed to reveal any useful risk factors. These findings would appear to agree with other similar studies[3,4] and it may be concluded that microbiological screening of all new colposcopy patients is not effective or economic.

However, our colposcopy clinic may not be representative in that patients found to have abnormal smear tests in genitourinary medicine clinics have already been screened prior to attendance for treatment at this hospital. Where this system does not operate the risk of STD may be consequently higher.